CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 18.17
TITLE: LIMIT ON RESIDENTIAL TREATMENT CENTER (RTC) CARE

AUTHORITY: 38 USC 1713; 38 CFR 17.270(a) and 17.272(a)(60)

RELATED AUTHORITY: P.L. 101-510 and P.L. 101-51 32 CFR 199.4(b)(8)

TRICARE POLICY MANUAL: Chapter 1, Section 12.1.B

I. EFFECTIVE DATE

RTC services provided on and after October 1, 1991.

II. POLICY

A. Inpatient mental health services received in a TRICARE certified residential treatment center (RTC) may be cost shared up to 150 days in a fiscal year.

B. Preadmission authorization is required for all nonemergency care in a RTC. Admission to a RTC is considered elective and not of an emergent nature. Certification of emergency type admissions are required within 72 hours. For admission to a RTC, a psychiatrist or clinical psychologist shall recommend admission and direct the treatment plan.

C. Treatment provided at a RTC may be cost shared for children and adolescents under 21 years of age.

III. POLICY CONSIDERATIONS

A. Congress established the specific day limits and a waiver authority. In order to give the day limits some meaningful effect, we must consider them presumptive limits, subject to waiver in special cases.

B. If the 150 day limit is reached, the waiver review is required.

C. Payment Responsibility

1. Payment responsibility. Providers may not hold patients liable for payment for services for which payment is disallowed due to the provider's failure to follow established procedures for preadmission and continued stay authorization. With respect to such services, providers may not seek payment from the patient or the patient's family, unless the patient has agreed to personally pay for the services knowing that payment would not be made.

2. If a request for waiver is filed, and the waiver is not granted by the Director (or designee) Health Administration Center (HAC), benefits would only be allowed for the period of care authorized.

IV. EXCEPTIONS

A. This limit does not apply to:

1. Any services provided in an acute inpatient mental health facility.

2. Any services provided as partial hospitalization (less than 24-hour-a-day care), if such services are covered.

B. Waiver of limits. There is a statutory presumption against the appropriateness of RTC services in excess of the 150 day limit. However, the Director (or designee), HAC, may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the RTC benefit limit and authorize payment for care beyond that limit.

1. Waiver of the 150 day limit may be granted if determined to be medically or psychologically necessary. In determining the medical or psychological necessity of services and supplies provided by RTCs, the evaluation conducted by the Director (or designee), HAC shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The criteria for waiver of the 150 day limit is listed in Chapter 2, Section 18.17.2, *Preauthorization Requirements for RTC Care*. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

a. Active treatment has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

b. The progress made is insufficient, due to the complexity of the illness, for the patient to be discharged to a less intensive level of care.

c. Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

d. The waiver request includes specific time frames and a specific plan of treatment that will lead to discharge.

2. Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required permitting appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit.

3. It is the responsibility of the patient's attending clinician to establish, through actual documentation from the medical record and other sources that the conditions for waiver exist.

C. For purposes of counting day limits only (not the reimbursement of services), a move from one facility to another facility can be considered a transfer when documentation establishes that coordination for the move existed between two like facilities for the purpose of ensuring continued treatment of the condition requiring the original admission. Under these circumstances, the admission to a new facility would be considered a continuous uninterrupted episode of care. If the documentation does not establish that coordination for the move existed between the two facilities, then the intent to transfer cannot be established and the move should be considered a discharge.

END OF POLICY